Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 12, 2015

Ms. Morgan Bovat, Administrator
Brownway Residence
328 School Street
Enosburg Falls, VT 05450-5500

Dear Ms. Bovat:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 17, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0118	A. BUILDING: _____ B. WING _____	C 12/17/2014

NAME OF PROVIDER DR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRDPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site visit was conducted on 12/16/14 and 12/17/14, by the Division of Licensing and Protection to investigate four entity self reports. The following regulatory violations were identified as a result of the investigation.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to develop a care plan that reflected all assessed needs of 1 of 4 residents reviewed. (Resident #2). Findings include: Per record review the care plan for Resident #2, who was admitted on 1/16/10 with a diagnosis of Traumatic Brain Injury and who had a history of angry outbursts and aggressive behaviors, did not reflect the behavior issues identified. Per review of progress notes the Monthly Summary, dated 3/28/14, stated that the resident experienced "mood swings from euphoria to angry outbursts to tears...." Subsequent progress notes, on 5/30/14, indicated that a request had been made by staff for "another PRN Ativan....for increase in angry outbursts of late..." and on 6/24/14, "Res noted to be having more mood swings of late. Will become very angry, confrontational as well as	R145	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE 12/29/14 (X6) DATE

Morgan Bovat Executive Director

R145, R181, R206, R213, R224 POCs accepted 1/9/15 PMcMahon

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R145	Continued From page 1 emotional, crying and yelling. Most often it's difficult to redirect res.....Most episodes occur in the late afternoon/evening. PRN Ativan with little effect." A health care provider note, dated 11/18/14, indicated Resident #2 was experiencing "emotional lability....more aggressive and hollering." Despite the increasing behaviors exhibited by the resident his/her care plan did not include goals or interventions to help guide/direct staff to meet the resident's needs in addressing these behaviors. During interview, on the afternoon of 12/17/14, both the home's Executive Director and RN (Registered Nurse) confirmed the resident's care plan did not address the behaviors.	R145	See attached	
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to	R181		

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R181	Continued From page 2 see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interview the home failed to assure the required background checks had been completed for 1 of 8 staff members reviewed. Findings include: Per record review PCA (personal care attendant) #5, who provided direct care to residents, did not have required background checks completed prior to, nor during, his/her 8 months of employment from September of 2013 to May 2014. The home's Executive Director confirmed, during interview on the morning of 12/17/14, that background checks had not been conducted on PCA #5.	R181	See attached	
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by:	R206		

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R206	Continued From page 3 Based on staff interviews and record review staff failed to assure a report of suspected abuse was made to APS (Adult Protective Services) in a timely manner. Findings include: Per record review PCAs (Personal Care Attendants/Direct Care Providers) #1, #2 and #8 failed to cause a report to be made to APS within 48 hours of becoming aware of an incident involving potential abuse and/or exploitation of Resident #3 by PCA #3. Per review of written statements by PCAs #1 & #2, documented on 10/2/14, each of them had become aware a few weeks prior to 10/2/14, of an incident in which PCA #3 had reportedly shown pornographic material to Resident #3. PCA #1 had reported that Resident #3 confirmed s/he had been shown a pornographic picture by PCA #3 and that PCA #3 had later asked the resident to lie to management about seeing the picture. Resident #3, who was not available to interview, reportedly told PCA #2 on the evening of 10/1/14, that s/he was not able to sleep and was nervous about talking with management about the incident. Despite the knowledge of the incident, it was not reported to APS until 10/2/14, when the home's Executive Director became aware of it. During interview, on the morning of 12/16/14, the home's Executive Director confirmed that PCAs #1, #2 and #8 had all failed to assure a report was made to APS within 48 hours of their knowledge of the incident.	R206	See attached	
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the	R213		

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R213	Continued From page 4 resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the home failed to assure that 2 of 4 residents reviewed were consistently treated in a respectful and dignified manner by all staff. (Residents #2 and #3). Findings include: 1. Per record review, Resident #2, who was admitted on 1/16/10 with a diagnosis of Traumatic Brain Injury and who had a history of angry and aggressive outbursts, was treated by 2 PCAs (Personal Care Attendants/Direct Care providers) in a manner that was disrespectful and undignified on the evening of 5/29/14. The resident reportedly approached the caregivers in an angry manner, yelling and swearing and the caregivers responded by telling the resident to "go to your room" and "oh grow up". During interview on the morning of 12/16/14 the home's Executive Director stated that a video recording of the incident had been viewed by management and s/he confirmed that the 2 PCAs had been verbally taunting Resident #2 during the interaction and a third PCA, though not involved in the verbal exchange, had made no attempt to intervene on behalf of the resident and stop the interaction. 3. Per review of written statements by PCAs #1 & #2, documented on 10/2/14, PCA #3 had reportedly shown pornographic material to Resident #3. PCA #1 had reported that Resident #3 confirmed s/he had been shown a pornographic picture by PCA #3 and that PCA #3 had later asked the resident to lie to management	R213	See attached	

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R213	Continued From page 5 about seeing the picture. Resident #3, who was not available to interview, reportedly told PCA #2 on the evening of 10/1/14, that s/he was not able to sleep and was nervous about talking with management about the incident. During the home's internal investigation Resident #3 reported to management that although s/he had asked PCA #3 to view the pornographic picture, PCA #3 had later approached Resident #3 and asked the resident to lie to management about seeing it. Resident #3 further stated that s/he was fearful of PCA #3 which is why the resident had not come forward to management with the information sooner. During interview, on the morning of 12/16/14, the home's Executive Director confirmed that both incidents had occurred.	R213	See attached	
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to assure that 3 of 4 residents reviewed remained free from verbal abuse and or exploitation. (Residents #1, #2 and #3). Findings include: 1. Per record review Resident #1, who was admitted to the facility on 12/9/10 and who was known to keep personal cash in his/her room,	R224		

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R224	Continued From page 6 had reported money missing in July of 2012. The home conducted an investigation and was unable to recover the missing money. The resident's care plan was revised to reflect the issue and interventions to prevent or reduce the risk of reocurrence. The resident again reported money missing in August of 2013, and, although there was a subsequent investigation by the home's management and attempts to find the money, it was not recovered. Despite the subsequent action taken, in which the resident allowed the home to assume responsibility for his/her funds, money was again noted to be missing from the resident's personal fund account in March of 2014. During an internal investigation by the home's management, a staff member, who had provided direct care for Resident #1 and who was aware of the resident's regular monthly cash intake, was identified as the party responsible for the missing funds in March 2014. 2. Per record review Resident #2, who was admitted on 1/16/10 with a diagnosis of Traumatic Brain Injury and who had a history of angry and aggressive outbursts, was treated by 2 PCAs (Personal Care Attendants/Direct Care providers) in a manner that was disrespectful, dismissive and ridiculing on the evening of 5/29/14. The resident reportedly approached the caregivers in an angry manner, yelling and swearing and the caregivers reportedly responded by telling the resident to "go to your room" and "oh grow up". During interview on the morning of 12/16/14 the home's Executive Director stated that a video recording of the incident had been viewed by management and s/he confirmed that 2 PCAs had been verbally taunting Resident #2 during the incident and a third PCA, though not involved in the verbal exchange had made no attempt to intervene on behalf of the resident and stop the	R224	See attached	

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R224	Continued From page 7 interaction. 3. Per review of written statements by PCAs #1 & #2, documented on 10/2/14, PCA #3 had reportedly shown pornographic material to Resident #3. PCA #1 had reported that Resident #3 confirmed s/he had been shown a pornographic picture by PCA #3 and that PCA #3 had later asked the resident to lie to management about seeing the picture. Resident #3, who was not available to interview, reportedly told PCA #2 on the evening of 10/1/14, that s/he was not able to sleep and was nervous about talking with management about the incident. During the home's internal investigation Resident #3 reported to management that although s/he had asked PCA #3 to view the pornographic picture, PCA #3 had, at a later date, asked the resident to lie to management about seeing it. Resident #3 further stated that s/he was fearful of PCA #3 which is why the resident had not come forward to management with the information sooner. During interview, on the morning of 12/16/14, the home's Executive Director confirmed that all three incidents had occurred.	R224	See attached	

R145

5.9.c Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independent and well-being;

1. Action to correct the deficiency

Health Services Director, Sheree Martel, RN, updated plan of care. Instead of "Monitor for negative behaviors", it has been updated to better reflect interventions to be used for the aggressive behaviors exhibited by Resident #2 (see attachment A).

Expected completion date: Completed (12/17/2014)

2. Measures to assure that it does not recur

Internal incident reports have been updated to reflect the need for care plan review following all behavioral incidents (see attachment A).

Expected completion date: Completed (12/19/2014)

3. How corrective actions will be monitored

Prior to signing off on internal behavioral incident reports, the Executive Director will assure that the plan of care has been updated as indicated by the incident report.

Expected completed date: Ongoing

R181

5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitations substantiated against him or her, as defined in 33 V.S.A Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont.

1. Action to correct the deficiency

During her employ, the Director of Finance was responsible for all background checks and failed to obtain the background check in September of 2013 prior to hiring Employee #5. Employee # 5 is no longer employed with Brownway Residence at this time.

Expected completion date: Completed

12/29/14

2. Measures to assure that it does not recur and how it will be monitored

Going forward, both the Business Office Manager and Executive Director must sign off on all completed background checks prior to staff being scheduled for training hours.

Expected completion date: Ongoing

R206

5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the APS as required by 33 V.S.A

1. Action to correct the deficiency

Facility was not made aware of the incident until the morning of 10/2/2014. At which time, it was reported, by the facility, to APS.

Despite PCA #1, #2, and #8 participation in the April 2014 Abuse, Neglect and Exploitation in-service, all three staff failed to follow their mandated reporter protocol.

On 10/3/2014, following the report to the facility on 10/2/2014, all three staff received written warnings and further coaching and supervision which included additional education regarding their mandated reporter status and the Statutes regarding failure to report Abuse, Neglect or Exploitation.

Expected completion date: Completed (10/3/2014)

2. Measures to assure that it does not recur and how it will be monitored

Facility utilizes the State of Vermont Raising Awareness training which is accompanied by a facility made worksheet which clearly addresses pornographic materials and the consequences of failing to make a mandated report (see attachment B). Facility, going forward, will continue to do due diligence by providing education to all new hires and staff regarding their mandated reporter status and their responsibility to report to either the Executive Director or APS within 48 hours of suspected abuse, neglect or exploitation.

Expected completion date: Ongoing

12/29/14

R213

6.1 Every resident shall be treated with consideration, respect and full recognition of the residents dignity, individuality, and privacy. A home may not ask a resident to waive the residents rights.

1. Action to correct the deficiency

1. Despite all three PCA attendances to the April 2014 in-service regarding Abuse, Neglect and Exploitation, after review of the camera footage on 5/30/2014, it was determined that all three staff engaged, inappropriately, with Resident #2. Both PCAs who were witnessed engaged in verbally taunting Resident #2 were terminated and the third PCA was terminated for not intervening on behalf of Resident #2.

Expected completion date: Completed (5/30/2014)

2. PCA #3 was terminated from employment with Brownway Residence.

Expected completion date: Completed (10/2/2014)

2. Measures to assure that it does not recur and how it will be monitored

Facility utilizes the State of Vermont Raising Awareness training which very clearly indicates emotional abuse as "yelling, swearing, name calling, bullying" on page 6 of the handbook. It also outlines that failure to "protect a vulnerable adult from abuse, neglect or exploitation by others" is categorized as neglect on page 8 of the handbook. Facility will continue to do due diligence by providing education to all new hires and staff regarding abuse, neglect or exploitation. Management will continue with supervision during off hours and be available to staff who are having difficulty with certain behaviors exhibited by residents.

Expected completion date: Ongoing

R224

6.12 Residents shall be free from mental, verbal or physical abuse, neglect and exploitation.

1. Action to correct the deficiency

1. After internal investigation regarding the March 2014 incident involving missing money, the PCA was seen, on camera, stealing the money from Resident #1. The PCA was immediately terminated from her employment.

Expected completion date: Completed (3/26/2014)

2. Despite all three PCA attendances to the April 2014 in-service regarding Abuse, Neglect and Exploitation, after review of the camera footage on 5/30/2014, it was determined that all three staff engaged, inappropriately, with Resident #2. Both PCAs who were witnessed engaged in

12/29/14

verbally taunting Resident #2 were terminated and the third PCA was terminated for not intervening on behalf of Resident #2.

Expected completion date: Completed (5/30/2014)

3. PCA #3 was terminated from employment with Brownway Residence.

Expected completion date: Completed (10/2/2014)

2. Measures to assure that it does not recur and how it will be monitored

Facility will continue to do due diligence by providing education to all new hires and staff regarding resident rights and abuse, neglect and exploitation. Management will continue with supervision during off hours.

Expected completion date: Ongoing

12/29/14